VERMONT
DEPARTMENT OF HEALTH

# 2019-2021 VERMONT ADULT VACCINE PROGRAM PROVIDER AGREEMENT

## FACILITY INFORMATION

| | | | |
|---|---|---|---|
| Facility Name: | | Facility NPI: | VAVP Pin#: |
| Facility Address: | | | |
| City: | County: | State: | Zip: |
| Telephone: | | Fax: | |
| Shipping Address (*if different than facility address):* | | | |
| City: | County: | State: | Zip: |

## MEDICAL DIRECTOR OR EQUIVALENT

**Instructions:** *The official VAVP registered health care provider signing the agreement must be a practitioner authorized to administer adult vaccines under state law who will also be held accountable for compliance by the entire organization and its VAVP providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

| | | |
|---|---|---|
| Last Name, First, MI: | Title: | Specialty: |
| License No.: | Medicaid or NPI No.: | Employer Identification No. *(optional):* |
| *Provide Information for second individual as needed:* | | |
| Last Name, First, MI: | Title: | Specialty: |
| License No.: | Medicaid or NPI No.: | Employer Identification No.: *(optional):* |

## VAVP VACCINE COORDINATOR

| | |
|---|---|
| **Primary Vaccine Coordinator Name:** | |
| Telephone: | Email: |
| Completed annual training:<br>○ Yes ○ No | Type of training received: |
| **Back-Up Vaccine Coordinator Name:** | |
| Telephone: | Email: |
| Completed annual training:<br>○ Yes ○ No | Type of training received: |

**PROVIDERS PRACTICING AT THIS FACILITY** *(additional spaces for providers at end of form)*

**Instructions:** *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

| Provider Name | Title | License No. | Medicaid or NPI No. | EIN *(Optional)* |
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## PROVIDER AGREEMENT

***To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:***

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|---|---|
| **1.** | I will annually submit a VAVP enrollment form or more frequently if there is a change in Medical Director or the population served. |
| **2.** | I will screen patients and document patients age at each immunization encounter for VAVP eligibility and administer VAVP-purchased vaccine only to adults age 19-64.<br><br>Adults aged 65 and older are **not** eligible to receive VAVP-purchased vaccine. |
| **3.** | For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VAVP program unless:<br>a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the adult;<br>b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions. |
| **4.** | I will maintain all records related to the VAVP program for a minimum of three years and upon request make these records available for review. VAVP records include, but are not limited to, VAVP screening documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records. |
| **5.** | I will immunize eligible adults with publicly supplied vaccine at no charge to the patient for the vaccine. |
| **6.** | I will not deny administration of a publicly purchased vaccine to an established patient because the individual of record is unable to pay the administration fee. |
| **7.** | I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Adulthood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). |
| **8.** | I will comply with the requirements for vaccine management including:<br>a) Ordering vaccine and maintaining appropriate vaccine inventories;<br>b) Not storing vaccine in dormitory-style units at any time;<br>c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Vermont Immunization Program storage and handling recommendations and requirements;<br>d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration |
| **9.** | I will participate in VAVP program compliance site visits including unannounced visits, and other educational opportunities associated with VAVP program requirements. |

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| **10.** | Vermont health care providers must report to Vermont Department of Health immunization data for adults 18 years and older, within one month after the health care provider has established an electronic health records system and data interface pursuant to the e-health standards developed by the Vermont information technology leaders. (Vermont Statutes Annotated, 18, Chapter 21 § 1129. Immunization Registry). |
| **11.** | I understand this facility or the Vermont Immunization Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Vermont Immunization Program. |

| | |
|---|---|
| ***By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vermont Adult Vaccine Program enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.*** | |
| Medical Director or Equivalent Name (print): | |
| Signature: | Date: |
| Name (print) *Second individual as needed*: | |
| Signature: | Date: |

| | |
|---|---|
| Number of adult patients | Total Number of Adults ages 19 – 64 |
| | |

# Vermont Adult Vaccine Program (VAVP) Program
# Provider Profile Form

*All health care providers participating in the Vermont Adult Vaccine Program (VAVP) program must complete this form annually or more frequently if the number of Adults served changes or the status of the facility changes during the calendar year.*

**Date: ___ ___ /___ ___/ ___ ___ ___ ___** **Provider Identification Number#_____**

| **FACILITY INFORMATION** | | |
|---|---|---|
| **Provider's Name:** | **Provider Email:** | |
| **Facility Name:** | | |
| **Vaccine Delivery Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Telephone:** | **Email:** | |

**FACILITY TYPE (select facility type)**

| Private Facilities | Public Facilities | |
|---|---|---|
| ☐ Private Hospital | ☐ Public Health Department Clinic | ☐ STD/HIV |
| ☐ Private Practice (solo/group/HMO) | ☐ Public Health Department Clinic as agent for FQHC/RHC-deputized | ☐ Family Planning |
| ☐ Private Practice (solo/groups as agent for FQHC/RHC-deputized) | ☐ Public Hospital | ☐ Correctional Facility |
| ☐ Community Health Center | ☐ FQHC/RHC (Community/Migrant/Rural) | ☐ Drug Treatment Facility |
| ☐ Pharmacy | ☐ Community Health Center | ☐ Migrant Health Facility |
| ☐ Birthing Hospital | ☐ Tribal/Indian Health Services Clinic | ☐ Refugee Health Facility |
| ☐ Other_____ | ☐ Other_____ | |

**VACCINES OFFERED (select all that apply)**

**Select Vaccines you would like to offer:**

| | | |
|---|---|---|
| ○ MMR | ○ Meningococcal Conjugate | ○ Influenza |
| ○ Hepatitis A | ○ TD | |
| ○ Hepatitis B | ○ Pneumococcal Conjugate | |
| ○ HZV (Shingles) | ○ Pneumococcal Polysaccharide | |
| ○ HPV | ○ Varicella | |
| ○ Tdap | ○ MENB | |

**PROVIDER POPULATION**

The following information is used to determine the amount of vaccine needed for your practice and **must be based on actual data,** not estimates. Provider Population is based on total patients seen at your facility.

**TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)**

| | |
|---|---|
| ○ Benchmarking | ○ Doses Administered |
| ○ Medicaid Claims | ○ Provider Encounter Data |
| ○ IIS | ○ Billing System |
| ○ Other (must describe): | |

# 2019-2021 Provider Agreement and Guidelines for Frozen Vaccines

**STORAGE REQUIREMENTS:** If you wish to receive frozen vaccine you will have to complete this signed agreement showing that your practice meets the following guidelines for proper storage and handling.

a) Merck & Company, Inc. the manufacturer of frozen vaccine will pack and ship vaccine directly to the provider office after receiving an order from CDC which is submitted through Vaccine Inventory Management System (VIMS).

b) Vaccines **MUST** be stored in a freezer, and **MUST** maintain temperatures between -15°C to -50°C (+5°F to -58°F ).

c) The freezer **MUST** have a separate door from the refrigerator, (e.g. stand alone freezer). Dorm-style or larger refrigerator/freezer combinations where the freezer is within the refrigerator is **NOT** acceptable.

d) A continues monitoring device (data logger) with current certificate of traceability and calibration must be placed in the freezer.

e) Freezer Max/Min temperatures must be recorded once a day as well as time and initials for each reading and any out of range temperatures **MUST** be reported to the Immunization Program immediately. Please call 1-802-863-7638.

f) State and/or VAVP supplied frozen vaccine **cannot be moved or redistributed from the provider site that received it without permission from the Vermont Immunization Program.**

**Practice PIN:** _____

**Practice Name:** _____

**Vaccine Contact Name:** _____

**Contact Telephone Number:** _____

I agree to the additional conditions herein for the storage, handling and use of varicella and zoster vaccine.

_____ _____

**Signature of Medical Director or Equivalent** **Date**